

DERMATOLOGY MEDICAL HISTORY

Patients Name: _____

Date: _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No If Yes, please list:

1. _____ 2. _____ 3. _____

Have you ever had dental anesthesia (Novocaine)? Yes No Any bad reaction? Yes No

List all medications that are currently taking, including prescriptions, over-the-counter, vitamins and herbs:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

Do you have now, or have you ever had the diseases or conditions of (please check YES or NO)

Cardiovascular:

Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Arrest	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Arrhythmias	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Catheterization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis/Blood Clot	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myocardial Infarction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	MVP/valve replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker/Defib	<input type="checkbox"/> Yes <input type="checkbox"/> No

Hematology/Lymphatic History:

Prolonged bleeding Yes No Hepatitis _____ Yes No
Prolonged swollen lymph nodes Yes No Blood Transfusions Yes No

GI History:

GI Ulcer Yes No

Neurology History:

Seizure Disorders Yes No Neuromuscular Disorders Yes No

Rheumatologic History:

painful/swollen joints Yes No

Endocrine History:

Cancer/Tumors Yes No

Diabetes Yes No

Infertility Yes No

TYPE _____

Immunologic History:

Respiratory History:

HIV/AIDS Yes No

Pulmonary Embolism Yes No

Irregular Menstrual Periods Yes No

Asthma Yes No

COPD Yes No

Dermatologic History:

Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Flaky Scalp	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fungal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes (cold sores)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Keloids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pre cancers (AK)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____	
Childhood blistering Sunburns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discoloration of the skin	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypersensitive skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal Wound Healing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry scaly skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abnormal hair growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	(if yes where on face or body)	
New or recently changed moles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe seasonal/dust allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No		

When exposed to the sun, do you? Tan only Tan and burn Burn

Please list any previous surgeries and date:

1. _____ 2. _____ 3. _____

Family History:

Please circle if there is a family history of the following:

Asthma mother father sibling Bleeding/clotting disorders mother father sibling Severe seasonal allergies mother father sibling
Cancer of Skin: Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma mother father sibling
Dysplastic nevi mother father sibling Eczema mother father sibling Psoriasis mother father sibling

Social History: Please answer YES or NO.

Are you nursing? Yes No Are you planning a pregnancy? Yes No Are you pregnant? Yes No

Do you drink alcohol? Yes No If YES, _____ drinks per day/week

What is your occupation? _____

What are your hobbies? _____

Have you ever been exposed to HIV/AIDS? Yes No

Do you use tobacco? Yes No How many? _____ per day/week

Form was

Completed by: Patient or Guardian

Medical Assistant _____

Patient or Guardian Signature

Date

(rev June 08) PT # _____

Reviewed By

Date

ISLAND DERMATOLOGY, P.C.
604 East Park Avenue Long Beach, NY 11561
358 Merrick Road Amityville, NY 11701

Name _____ Date of Birth _____ Sex _____
Address _____ City _____ State _____ Zip _____
E-Mail _____ Home Phone _____ Social Security # _____
Business Phone _____ Occupation _____
Primary Insurance Co. _____ Policy No. _____ Group No. _____
Name of Policyholder _____ DOB Policyholder _____ Social Security # Policyholder _____
Secondary Insurance Co. _____ Policy No. _____ Group No. _____
Name of Policyholder _____ DOB Policyholder _____ Social Security # Policyholder _____
Referred by: _____

TO ALL PATIENTS – PLEASE ANSWER “YES” OR “NO”

It is strongly recommended, at the initial visit, that you have the Doctor examine your entire skin surface. Even if you have just been to your family physician, it is recommended that you have your Dermatologist examine your skin, thus extending, but not replacing a complete physical examination by your family physician. If you desire this examination, you will be given a disposable gown. Please completely disrobe to allow the Doctor to view your entire skin surface for medically important benign or malignant lesions. Do you wish this examination? Yes No

TO ALL PATIENTS

In order to submit a claim for payment to us for services covered under your policy, we must have authorization to release medical information to your insurance carrier.

MEDICARE

Name of Beneficiary _____ HI Claim Number _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ISLAND DERMATOLOGY for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVII of the Social Security Act.

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature

Date

ISLAND DERMATOLOGY, PC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION & WRITTEN RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby give my consent for Island Dermatology, PC to use and disclose protected health information (PHI) about me **to carry out treatment, payment and healthcare operations (TPO)**. Island Dermatology's "Notice of Privacy Practices" provides a more complete description of such uses and disclosures. I have the right to review the "Notice of Privacy Practices" prior to signing this consent. Island Dermatology reserves the right to revise its "Notice of Privacy Practices" at anytime. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Island Dermatology, PC Privacy Officer at: 604 East Park Avenue, Long Beach, New York 11561

PLEASE CROSS OFF ANY ITEM BELOW THAT YOU DO NOT GIVE ISLAND DERMATOLOGY, PC PERMISSION TO PERFORM (If any one item is a "no" then a whole number is out)

With this consent, Island Dermatology, PC may;

- 1) Call my home or cell phone and leave a message on voicemail or in person in reference to any items that assist that practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory & biopsy results, among others.
- 2) At any alternative location will leave a message on my personal voicemail or in person in reference to any items or any calls pertaining only to my clinical care, including laboratory & biopsy results, among others. **However, at any alternative location call, Island Dermatology, PC will not leave a message about my medical condition or lab result with any other person.**
- 3) Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.
- 4) If I decide to give you my e-mail address you may use it only to assist the practice in carrying out TPO, including appointment reminder and patient statements.
- 5) Answer about my health & care with family members. **If this discussion is on the phone, the family member must identify me with my social security number!**
- 6) Treat my minor, if they come without me, in an office visit.

I have the right to request that Island Dermatology, PC restrict how it uses and discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Island Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. If I do not sign this consent, or later revoke it, Island Dermatology, PC may decline to provide treatment to me.

I have received a copy of Island Dermatology, PC's "Notice of Privacy Practices".

Signature of Patient or Legal Guardian

Print Name of Patient's Legal Guardian

Patient's Name

Date

FOR OFFICE USE ONLY:

PT #: _____